Chapter Three

Provider Information

Chapter Overview

Introduction

This chapter gives information on the qualifications and requirements of ambulance providers, how to enroll in the Medicaid program, and how to report changes in provider information.

In This Chapter

This chapter covers the following topics:

Enrollment

Qualification

The Ambulance Services provider must

- be licensed by The North Carolina Division of Facility Services, Office of Emergency Management Services, and
- participate as an ambulance provider in the Medicare program.

Out of State

The ambulance service provider must:

1. Be licensed as an ambulance provider under the laws of the state in which the provider operates
2. Be enrolled as a Medicaid ambulance provider in the state in which the provider operates
3. Participate in the Medicare program as an ambulance provider

Agreement

The ambulance service provider must complete a Medicaid Participation Agreement. Upon execution of the agreement, DMA assigns a provider number. The provider can bill for services on or after the effective enrollment date approved by DMA. The Medicaid fiscal agent must receive claims within 365 days of the date of service, or within 180 days after Medicare adjudication, whichever is later.

Conditions of Participation

Payment in Full

The ambulance provider must agree to accept reimbursement as payment in full for all Medicaid services provided plus any authorized deductible, co-insurance and third party payment.

A provider cannot deny services to any Medicaid patient due to the individual's inability to pay a deductible, co-insurance or co-payment amount specified in 10 NCAC 26C.0003. An individual's inability to pay does not eliminate his responsibility for the cost sharing charge.

A provider may pursue recovery of third party funds that are primary to Medicaid.

Reassignment of Claims/Payments

Medicaid payments are made only to:

- The enrolled provider who renders the services billed, or
- A business agent that furnishes statements and receives payments in the name of the provider. The agent's compensation must be related to the cost of processing the billing; it cannot be based on a percentage or other non-cost basis to the amount billed or collected nor can it be dependent on collection of the payment

Payments may be reassigned by:

- The provider to a government agency or
- Court order to another entity

Medicaid payments are prohibited to or through an individual or organization that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the organization for a fee or percentage of the accounts receivable.

Civil Rights Act

The ambulance provider must comply with Title VI of the Civil Rights Act of 1964 that states, "No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation under any program or activity receiving Federal financial assistance."

Rehabilitation and Disabilities

The ambulance provider must comply with the following requirements in addition to the laws specifically pertaining to Medicaid:

- **Section 504 of the Rehabilitation Act of 1973**, as amended, which states, "No otherwise qualified handicapped individual in the United States shall solely by reason of his handicap, be excluded from the participation in, be denied the benefit of, or be subject to discrimination under any program or activity receiving Federal financial assistance."
- **The Americans with Disabilities Act of 1990**, which prohibits exclusion from participation in or denial of services because the agency's facilities are not accessible to individuals with a disability.
- **The Age Discrimination Act of 1975**, as amended, which states, "No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance."

Program Integrity Reviews

Program Integrity (PI)

Program Integrity (PI) operates under federal and state laws and regulations that are both stringent and comprehensive. The state rules are found in the NC Administrative Code Title 10, Section 26G, and the federal rules are found in 42 CFR 455.

Information regarding requirements resulting from these laws and rules are provided through provider manuals and monthly Medicaid Bulletins.

PI Mission

It is the mission of the DMA Program Integrity Section to insure that:

- Medicaid dollars are paid correctly by identifying overpayments to providers and recipients occurring due to error, abuse, or fraud
- Overpayments are recovered and the proper agencies are informed of any potentially fraudulent actions
- Recipients' rights are protected and recipients receive quality care
- Problems found are communicated to appropriate staff, providers or recipients and corrected through education and/or changes to the policy, procedure, or process, and monitored for corrective action

Mission Achievement

The mission is achieved by PI:

- conducting post payment reviews of
  - ▷ provider billing practices and cost reports
  - ▷ payment of claims by the fiscal agent
  - ▷ recipient eligibility determinations
- identifying overpayments for recoupment
- identifying medical, administrative, and reimbursement policies or procedures that need to be changed
- educating providers on errors made
- assessing the quality of care for Medicaid recipients
- assuring that Medicaid pays for only medically necessary services
- identifying and referring suspected Medicaid fraud cases to the Attorney General's Office Medical Investigations Unit (AGO MIU), other state agencies, professional boards (e.g., boards of pharmacy, dentistry, etc.), or to federal agencies for investigations (e.g., DEA)
- overseeing recipient fraud and abuse activities by the county departments of social services to assure that recipient overpayments are recouped

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Program Integrity Reviews, continued

Determining Areas For Review

PI reviews are initiated for a variety of reasons. The following are some common examples (list not all-inclusive):

- PI investigates specific complaints and referrals. These may come from recipients, family members, providers, state or county agencies, or other DMA sections
- The quarterly Surveillance and Utilization review Subsystem (SURS) reports identify providers and recipients whose billing patterns or use of services exceed the norm for their peer groups
- Special ad-hoc computer reports are run that target specific issues, procedure codes, or duplications of services, etc.
- Identified billing errors and problems can be linked among similar provider groups and may generate additional investigations to determine their prevalence
- Random sampling of all claim types are reviewed for possible fraud and abuse
- EDS refers questionable services identified during claims processing to PI

Provider Responsibilities With a PI Review

If notified that PI has initiated a review, a provider can ensure the review will be both positive and educational by adhering to the following:

- PI will request medical and/or financial records either by mail or in person. EDS, as the fiscal agent for DMA, may also request records. The records must substantiate all services and billings to Medicaid. Failure to submit the requested records will result in recoupment of all payments for the services. You must maintain records for five years in accordance with the recordkeeping provisions of your provider participation agreement.

- If you receive a recoupment letter from PI, review the information and details in the letter and chart. You have two (2) options:

1. If you agree that an overpayment has occurred, use the form sent with the letter to indicate your preferred method for reimbursing DMA. The options include sending a check or having the repayment withheld from future Medicaid payments. (Send the check to DMA Accounts Receivable at the address on the letter. Do not send the check to EDS as this could result in duplication of your recoupment.)
2. If you disagree with the overpayment decision by PI and want a reconsideration review, then return the enclosed hearing request form to the DMA Hearing Unit (at the address on the letter) and indicate whether you request a personal hearing or a paper review. **Please pay close attention to the time frames and procedures for requesting a reconsideration review.**

Personal hearings – These are held in Raleigh and the Hearing Unit will assign the date, time, and place. You will be notified in writing of the Hearing Officer's final decision after the personal hearing.

Paper reviews – You may instead send additional relevant documentation to the Hearing Unit for reconsideration. Your written material will then be evaluated and a final decision rendered.

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Program Integrity Reviews, continued

Miscellaneous

1. If you or your staff need assistance and/or education, call EDS at 919-851-8888 or 1-800-688-6696 and request a provider education contact.

2. If you call EDS or DMA to get clarification of policy, it is helpful if you record the date, name of staff person talked with, the policy issue discussed, and a summary of the guidance given.

3. You have the responsibility to maintain the provider manuals and Medicaid Bulletins and assure that all staff who plan care, supervise services, and file claims for Medicaid reimbursement have access to the Medicaid guidelines.

Self Referral Federal Regulation

For Medicaid payments, OBRA 1993 prohibits self referral by a physician to designated health services in which the physician has certain ownership of compensation arrangements. If post payment review determines that inappropriate payments were made due to the providers' failure to follow Medicaid policies, recoupments will be made. Exceptions are listed in OBRA 1993 and in section 1877 of the Social Security Act.

Designated health services include the following:

- clinical laboratory services
- physical and occupational therapy services
- radiation therapy services
- hearing aids
- ambulance services
- parenteral and enteral nutrition equipment and supplies
- prosthetic and orthotic devices
- home dialysis
- contact lenses
- eyeglasses
- home infusion therapy services
- Radiology services (including magnetic resonance imaging, computerized axail tomography scans, and ultrasound services)
- durable medical equipment
- comprehensive outpatient rehabilitation facility services
- outpatient drugs
- home health services
- inpatient and outpatient hospital services

Provider Responsibilities

Verifying Eligibility

The ambulance provider is responsible for verifying Medicaid eligibility each time a recipient presents for services. Information on ways to verify Medicaid eligibility is provided under the "Medicaid Eligibility" section in Chapter Two.

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Provider Responsibilities, continued

Acceptance of a Medicaid Patient

The acceptance of a Medicaid patient by a provider includes, but is not limited to:

1. entering the patient's Medicaid number or card into any sort of patient record or general record keeping system
2. obtaining other proof of Medicaid eligibility
3. filing a Medicaid claim for services provided

Requesting Medicaid Acceptance

The patient or patient's representative must request acceptance as a Medicaid patient by:

1. presenting the patient's Medicaid card or Medicaid number orally or in writing
2. stating orally or in writing the patient has Medicaid coverage
3. requesting acceptance of Medicaid upon approval of pending application or review of continuing eligibility

Recipient Billing

A provider may refuse to accept a patient as a Medicaid patient and bill the patient as private pay only if the provider informs the patient prior to rendering a service that Medicaid will not be billed by the provider for any services but will charge the patient for all services provided.

A Medicaid recipient may only be billed for:

- a noncovered service, when the recipient was informed, prior to the service, that Medicaid would not pay for the service.
- services rendered for which proof of Medicaid eligibility cannot be obtained
- services rendered to a patient ineligible for Medicaid
- services for which either commercial insurance or Medicare reimbursed the recipient and not the ambulance provider
- Medicaid-covered services for a recipient who is Medicare-eligible because of age (65 or older), but who failed to supply a Medicare number as proof of coverage
- patient is no longer eligible for Medicaid

The above is defined in 10NCAC, Chapter 26.

Billing Restrictions

A Medicaid recipient <u>cannot</u> be billed for services which the provider receives no reimbursement from Medicaid when:

- the provider failed to follow program regulations
- the agency denied on the basis of lack of medical necessity
- the provider is attempting to bill Medicaid beyond the situations as stated in "Recipient Billing" above

Retroactive Eligibility

If the provider accepts a patient as private pay and bills for services covered under Medicaid for Medicaid patients, and the patient is later found retroactively eligible for Medicaid, the provider may file for reimbursement. The provider must refund the patient all money paid by the patient for the services covered by Medicaid with the exception of any third party payments or cost sharing amounts.

Reporting Changes In Provider Information

Provider Changes Requiring Notification

Certain changes made by an ambulance provider require written notification to DFS and DMA. These changes must be reported in writing on the ambulance provider letterhead and signed by an authorized employee of the facility. Include in the letter all provider numbers assigned as well as the effective date of the change.

See Appendix B for appropriate DMA and DFS phone numbers and addresses.

The following changes require written notification:

Type of Change	Documentation Required
• Name Changes • Change of Ownership	Indicate the new information in a letter to DFS and DMA. DFS processes information and notifies DMA of changes. DMA will send a Participation Agreement to the facility for changes requiring a new Participation Agreement.
Change in the Physical Location of the Facility	Requires re-enrollment by DFS, HCFA and DMA.
Tax Identification Number and/or Name Changes	Inform DFS and DMA in writing of the change and attach a completed and signed W-9 form.*

*** Note**: W-9 forms are available from IRS.